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Making the Case
for **High-functioning,**
Team-based Care in

COMMUNITY BEHAVIORAL HEALTH CARE SETTINGS

NATIONAL COU
DIREC R TITUTE

ACKNOWLEDGEMENTS

MEDICAL DIRECTOR INSTITUTE

The Board of the National Council for Behavioral Health authorized the National Council Medical Director Institute (MDI), which includes medical directors from mental health and addiction treatment and recovery organizations from across the country, in 2015. Drawing from the members' diverse breadth of knowledge and experience, the MDI advises National Council members on best clinical practices and develops policy and initiatives that serve member mental health and addiction treatment and recovery organizations, their constituent clinicians and the governmental agencies and payers that support them.

The MDI developed this paper with input from medical directors, subject matter experts and experienced behavioral health providers and clinical sta with first-hand experience in direct service provision and administration.

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INTRODUCTION

AIM OF PAPER

This paper describes team-based care as the model of delivering mental health and substance use disorder treatment services in community behavioral health clinics (CBHCs) to improve individual care, population health outcomes and the work experiences of all team members who provide care. The paper also presents five critical elements of the model that are necessary for high-functioning team-based care in the CBHC setting and actionable tips for implementation.

Team-based mental health care is often pursued simultaneously with primary care integration, which is sometimes referred to as "reverse integration." However, CBHCs that have not yet pursued either team-based care or primary care integration should first implement team-based care before tackling primary care integration. Team-based care principles are closely aligned with integration principles, such as the Quadruple Aim (Bodenheimer, 2014) and can set CBHCs for success in improving the personal experience of care, improving the health of individual persons and populations, reducing the per capita cost of health care and improving the sta experience of care provision.

CBHC leaders and sta should use this paper as a resource as they begin to consider, plan for and implement team-based care in their organization.

TERMINOLOGY

Nomenclature relating to behavioral health and addiction has evolved rapidly in an attempt to keep up with changes in practice. Notable examples are the introduction of non-physician psychiatric providers as an important part of the psychiatric workforce and respectfully referring to the people we serve. For the purposes of this paper, we will use the following terminology:

- **Behavioral health care:** Includes mental health and substance use disorder treatment services.
- **Community behavioral health center (CBHC):** An agency that provide a comprehensive range of mental health and substance use disorder services to individuals in their communities.
- **People (or person) receiving services:** Because person-first language (Kirszenbaum, 2015) is the contemporary standard, "people (or person) receiving services" is used in this document in place of patients, clients and consumers. Exceptions are when referring to the specific primary care model of patient-centered primary care or medical home and when quoting a source directly.
- **Psychiatric provider:** Psychiatric providers i-USAn agency that pro5 (t pr)28 (e wiMC nurangu. Notable .1 (of t5.35 (y)r)25

EXECUTIVE SUMMARY

Despite a wealth of data showing that team-based care leads to equal or better outcomes in e□ciency, e□ectiveness, safety, cost savings and quality, the broad adoption of team-based care in CBHCs remains the exception rather than the rule. Primary care models, such as patient-centered medical homes (PCMHs), have generated much of this data, but some has also come from behavioral health implementations.

Delivering competent behavioral health care has become more complex in recent years. A renewed focus on social determinants of health and the screening and coordination of physical illness in individuals with serious

THE CURRENT STATE OF BEHAVIORAL HEALTH CARE IN CBHCs

CBHCs are expanding the quality of care provided to people with SMI and improving mental health and addiction treatment and recovery outcomes in a progressively more complex population at a time we are also called upon to improve physical health outcomes, address social determinants of health, reduce all-cause medical spending and constrain mental health and addiction services costs. It is essential to consistently meet these value-based performance expectations and maintain access to care. To achieve such performance standards, CBHCs must overcome barriers that include addressing increased sta workloads, improving coordination within and across systems and preserving sta well-being

The importance of having a positive impact on the general health, early mortality and number of chronic medical conditions seen in tandem with SMI cannot be understated. In 2006, the National Association of State Mental Health Program Directors (NASMHPD) reported that people with SMI die, on average, 25 years earlier than the general population. In spite of significant e orts during the past decade, the gap in life expectancy has not significantly changed (Olfson, 2017).

In response to concerns around the quality of health monitoring practices and physical care service delivery in mental health and addiction treatment and recovery care, the National Quality Forum (NQF) and other regulatory entities and payers have started shifting their quality measures from process measures to outcome measures (Burstin, 2016). These measures are being incorporated into various value-based payment models; however this results in an array of tasks and requires direct involvement and expertise of all behavioral health care providers in close coordination with each other and other treatment providers (Druss, 2018; Torrey, 2017).

While facing increased performance expectations, CBHCs are having di culty sustaining adequate numbers of psychiatric

THE SOLUTION

Primary care providers have responded to these challenges by adopting team-based care. Work from the World Health

Although medication-centered clinics initially appear to be e cient, the literature in the U.S. and internationally clearly states that “there is near consensus that community-based integrated and comprehensive psychiatric services performed by interdisciplinary teams constitutes the gold-standard for the care of persons su ering from mental illness,” (von Peter, 2018; Liberman, 2001). People receiving services need access to professionals with diverse and complementary skillsets across all specialties that function as a unit with clear roles, a shared purpose and seamless coordination to e ectively and e ciently deliver comprehensive, individualized, responsive care to treat acute need. (Schuttner, 2018).

The clinical complexity and aspirations of improved behavioral and physical health performance have outpaced the ability of any single sta member to manage. This includes psychiatric providers and nursing sta who cannot deliver all the needed aspects of behavioral health and medical care in the psychiatric clinic without the support of a high-functioning team (Nutting, 2011; Torrey, 2017). Incorporating all providers as full members of the team adds value to the care of the person receiving services and optimizes communication between all team members, which clarifies the diagnostic picture and highlights social determinants of health needs and other barriers to care. Because all members of the team are responsible for the same people receiving services, there are fewer communication errors. The psychiatric provider and the nursing sta can lead the team in monitoring and supporting the physical health of people receiving services

THE EVIDENCE

A robust evidence base supports high-functioning team-based care e□cacy in the **physical health literature.** High-functioning teams have delivered outcomes superior to standard care in acute and chronic care settings, including:

- **Increased access** to care and reduced complications (Weller, 2014).
- **Improved safety, reduced errors and better communication** (Smith, 2018; Dehmer, 2016).
- **Reduced hospital admissions**, emergency department utilization, 30-day all-cause readmissions and length of stay (English, 2017; AHRQ, 2016; von Peter, 2018).
- **Improved clinical outcomes** for hypertension and diabetes and reduced mortality rates (WHO, 2010).
- **Improved satisfaction** of people receiving services, including greater acceptance of treatment (WHO, 2010).
- **Decreased provider burnout**, turnover and tension and conflict among care providers (WHO, 2010) and **increased provider productivi1mpro**

3. Structured Yet Flexible Decision-making Processes

E cient and e ective teaming can only occur if team members establish flexible and psychologically safe communication and decision-making patterns. Communication must be both extemporaneous with activities like curbside consults and structured through regularly scheduled meetings like team huddles. Role definitions help make it clear who has the authority to make certain decisions. However, hundreds of decisions are made during the course of any day; some have the potential for significant legal liability, while others have significant potential to engage or disengage a person in care. Health care providers' decisions carry significant weight and teams must spend time to determine when individual sta can make a decision, when it makes sense to collaborate on a decision and in what context to do this, for example, waiting until a team meeting or under supervision.

4. Open and Safe Communication

"Psychological safety is a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes," (Edmonson, 2012). Google researched which components make a team e cient and e ective and found that psychological safety was the most positively correlated variable. If there is only one variable to focus on when considering how to improve team e ciency and e ectiveness, this is it (Google, 2012). Sta members who feel they have a say in their workflow have much lower burnout rates (Maria, 2011) and higher employment satisfac 8 e ciency and e , 2012). Sta

A PROPOSED MODEL FOR HIGH-FUNCTIONING, TEAM-BASED CARE IN COMMUNITY BEHAVIORAL HEALTH CARE

What does high-functioning, team-based care in a CBHC look like? The team-based care principles just described

Implementation Team

Once a CBHC has established leadership sponsorship for team-based care implementation, they must identify an implementation champion and assemble an implementation team, which is an interdisciplinary group of sta from across the organization. The implementation team is critical to facilitating organizational change and sta engagement. Under the champion's leadership, the implementation team defines the project mission, conducts an organizational self-assessment to determine baseline clinical and operational strengths and needs, and develops an implementation action plan.

HIGH-FUNCTIONING TEAMS

Developing and Maintaining an E ective Team

- Include sta members in developing and implementing the model so they are engaged in the process and are not passive participants.
- Create team-based incentives for meeting goals for team-based care, for example, success at meeting metabolic monitoring goals.
- Regularly assess team and individual clinical and administrative performance measures to facilitate achievement of goals.
- Hold regular team meetings to discuss how the team is performing, problems, concerns, successes, expectations, etc.
- Use language that constantly promotes and reinforces the idea of "teamness" like "we" versus "I" or "you" and "teaming" – collaborative support of one another.
- Foster a sense of psychological safety among teams. This means creating an environment where sta members feel respected and safe to share ideas, raise criticisms or concerns, ask questions and suggest solutions without fear of embarrassment or retribution. Without psychological safety, teams become ine ective due to their inability to identify and solve problems, exchange ideas and push against the status quo and adopt innovative change. Leaders and team members can foster a sense of psychological safety by ensuring everyone has an opportunity to speak and weigh in on decisions regardless of their position and status within the organization, encouraging constructive criticism, and making "I" statements.
- Emphasize the notion of collective responsibility and accountability so each team member understands that they play an important role in making team-based care successful.
- Engage in ongoing and widespread communication. Culture change requires ensuring team members understand the reasons for adopting team-based care. If they do not understand how and why it leads to better outcomes, they are not as likely to support it. Team members need consistent expressions of support from leadership about the appropriateness and necessity of these changes, as well as opportunities to voice their thoughts and ideas.

Required Skills and Attributes for All Team Members

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others to disagree and praise and thank those who do o□er a di□erent viewpoint. In a team discussion, silence does not always mean everyone agrees; therefore, e□ective team leaders establish an obligation to dissent so that discussions can take place openly. Otherwise, it is likely that these conversations will happen in isolated pockets, behind closed doors to the detriment of the team. If a team member suspects that unearthed disagreement is lurking in the room, they should gently demand that it be addressed. Using this concept of mining for conflict, team members can experience conflict not as a personal attack but rather as an opportunity to obtain greater clarity.

- **Possess a strong sense of accountability,** whereby team members hold themselves and others accountable for adherence to the agreed-upon workflow and the overall success of the process. Holding each other accountable is the most di□cult part of e□ective teamwork and requires the most discussion and development to achieve.
- **Dedication to a continuous quality improvement process** for achieving administrative e□ciency, quality of care and improved clinical outcomes.

Defined Team Structure and Sta□ng Roles

Team-based care requires clear roles, expectations and accountability. This foundation allows for task shifting, a concept initially developed in areas of the world faced with chronic workforce shortages, that has proven to be e□ective in other settings (WHO, 2018). Task shifting focuses on ensuring that all sta□ are working at the top of their professional training by reassigning tasks from one type of health professional to another, while ensuring care is high quality and that all legal requirements of scope of practice are met.

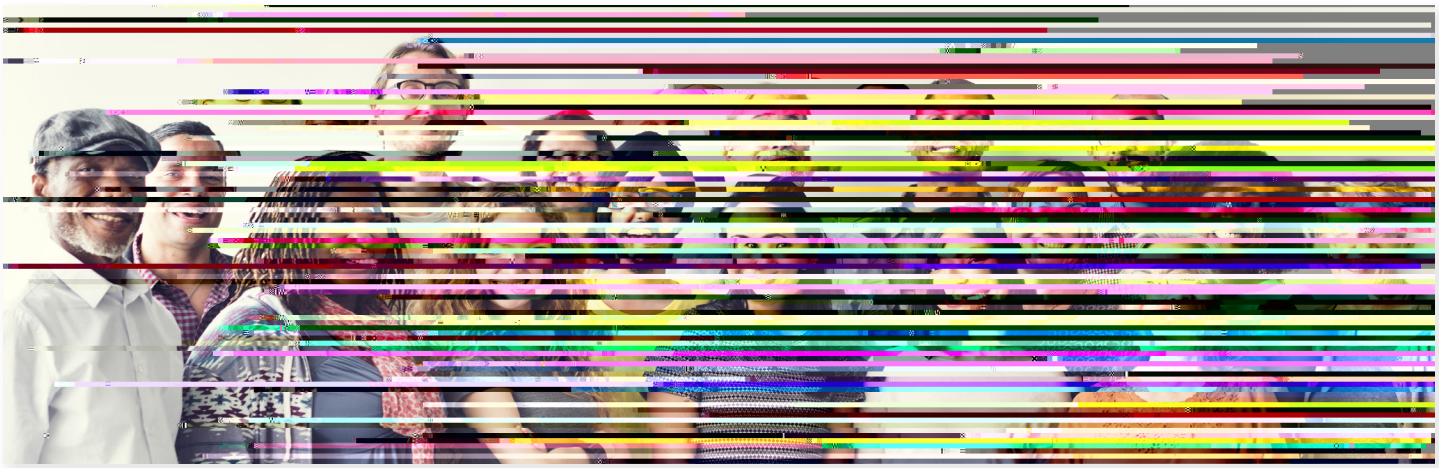
At first, task shifting might appear to be merely a cost savings measure; however, in practice, it can free sta□ to deliver care more e□ectively. For example, by using a trained medical assistant (MA) to obtain a person's vitals, rather than a registered nurse (RN), the RN can use their advanced skills to coach the person on health issues and coordinate care with primary care providers. Another example of task shifting is having a clerical sta□ person gather all the clinical information, such as hospital records or recent labs, prior to the appointment. This spares the psychiatric provider the additional task of searching the person's chart for missing information and requesting the information, which they would have to review at a later time.

Implementation Tip

Your team can analyze how to shift tasks by first identifying a list of all necessary tasks, then asking the following questions of each task:

1. Who is currently responsible for this task?
2. Who should be responsible for this task?
3. What additional training is required for the appropriate team member to become responsible for this task?
4. Would e□ciency be enhanced by developing protocols to complete this task?
5. Which team members should develop these protocols?

Once the team has analyzed tasks and assigned them to the appropriate team members, the team structure and roles should be finalized. The team should be led by a psychiatric medical director-clinical director dyad that leverages the psychiatric and clinical expertise of teams to lead to clinical and financial improvements. While the medical director and clinical director will need to allocate additional time to serving in this operational leadership role, the team-based care model o□ers other e□ciencies to o□set the reduction in available clinical time for these sta□ members (Rosen, 2019).



Clearly Defined Team Norms

Once the team is assembled, members need to establish team norms. Norms are the behaviors team members engage in daily to achieve their shared goals. Often norms are not made explicit through discussion and emerge as a byproduct of interaction and drive team activities. Teams that are thoughtful and deliberate about their norms, including how they interact with one another and the people they serve, the language they use and the demeanor and follow-through on commitments to excellence in health care provision, are in the best position to continually learn and improve on team-based care delivery. Teams should engage in a collaborative process by which they define and adopt a set of norms.

Implementation Tip

The following are sample norms to consider:

- The team continuously defines, practices and refines standard operating procedures by tracking data to monitor the e□ciency and e□ectiveness of protocol-informed workflows to achieve population process and outcomes targets.
- The team provides person-centered care and delivers the right services at the right times by the right team members. Care includes engagement, health literacy and education.
- The whole team is responsible for the whole population served. The daily work is not getting through schedules or completing other tasks, it is the health of the population of people they serve.
- All team members are dedicated to the integrated health and wellness of the population served and the wellness of their team and its members.
- All team members have defined roles and work to the top of their skills and/or licensure.
- All team members operate from the perspective that they can and will assist others when needed within their scope of work or through coordination with a team member who can.

Team Communication Mechanisms

Communication among team members should happen in a variety of structured and unstructured ways, including

MEASUREMENT-BASED CARE PATHWAYS AND PROTOCOLS

Measurement-based care, care pathways, and clinical and operational protocols are three elements of mental health service delivery that work together to provide a solid foundation for team-based care implementation. A care pathway is a sequential series of clinical and administrative activities (or workflow) that sta engage in to provide care to people receiving services (Morris & Trivedi, 2011; Trivedi, 2006). Grounded in the available evidence-based research and best practice literature, care pathways are designed to provide the needed standard operating procedures for addressing clinical activities, care coordination, billing, documentation, sta time allocation and data reporting required for each step in the workflow process.

Care pathways should be developed within a measurement-based care (MBC) framework. MBC is the practice of basing clinical care on client data collected throughout treatment and is considered a core component of numerous evidence-based practices. MBC can be used to assess valuable information about (a) signs/symptoms, (b) functioning and satisfaction with life, (c) readiness to change and (d) the treatment process via session feedback and a working alliance (Scott, 2015). This objective assessment of progress can be used to initiate modifications to treatment of the individual and to monitor population health and the overall e ectiveness of services. In additional to developing clinical measures and benchmarks, CBHOs should develop operational measures and benchmarks in order to engage in a comprehensive continuous quality improvement process.

Lastly, care pathway protocols ensure proper execution of the care pathway workflow and a ord the team:

1. Clarity around how, when and by whom critical workflow processes within the care pathways are completed.
2. A system within which to advance and sustain MBC where all clinical and operational activities have process and outcome metrics and benchmarks (e.g., individual and population health outcomes, billing and documentation).
3. The ability to engaging in real-time continuous quality improvement by isolating and changing one element of a workflow protocol using the Plan Do Study Act (PDSA) approach to see if it creates the desired outcome.

Care pathway protocols should be clearly laid out into easy-to-reference steps. Teams often use flowcharts to depict the sequence of work delegated to various team members. Though incorporating protocols is critical, not all care pathway workflow steps should be written into protocols – there are too many things a team does in a day. It is best to start by identifying which protocols are currently in place, if they accurately depict how sta are working, and most importantly, if they are producing the desired measurement-based results. Once the team has analyzed and refined current protocols, determine if the workflow could be enhanced by developing additional protocols or adding or refining measurements and benchmarks.

Implementation Tip

For more information on developing care pathways and protocols, see the National Council's Toolkit for Designing and Implementing Care Pathways.

PERSON-SERVED ENGAGEMENT

People served should be engaged early and often when a CBHO implements changes to care pathways as a result of adopting team-based care. The following are considerations for communicating for engagement:

- Conduct focus groups before implementation to explore person-served concerns about and hopes for the team-based care initiative. Concerns may include changing providers, confidentiality and knowing who to contact. Hopes may include working with a team that knows them well and rapid access to support and expertise.
- Prepare team members to talk with people served about the concept of team-based behavioral health care by developing an “elevator speech” that can help them organize and present the concepts behind providing care in a new way.
- Provide orientation sessions for people served.
- Have people served meet the entire team at the beginning of treatment.
- Create informational materials (e.g., one-page descriptions).
- O□er avenues for ongoing person-served involvement and feedback on the process. For example, send post-care satisfaction surveys and/or set time aside during care appointments for providers to illicit feedback.

TRAINING AND COMMUNICATION

Plan to provide sta□ access to training, mentoring and support for skills needed to function as a fully deployed high-functioning team. Training should be provided during the implementation phase and on an ongoing basis for continuous quality improvement and sustainability. Be prepared to consistently communicate with sta□ the importance of team-based care, the successes of implementation and areas for future development to maintain sta□ engagement. As stated by Ling et al. (2017), “Tyng ta dauang hall e (oc)(elop) (sang ()20 (Tmr)2]TJEe pr(. M)(oskills ,ing and s

Even within a mental health fee-for-service model, some team care services and roles are potentially billable as peer support, case management, crisis services or psychosocial rehabilitation. Potentially billable team care services/activities could include:

- Obtaining symptom rating scales (PHQ-9, GAD-7).
- Completing a medication adherence and recent history review and reassessment.
- Assisting the person with questions they have for the psychiatric provider.

These activities fall under broad descriptions of skill building, self-management and improving personal interactions that are standard parts of the service descriptions of peer support, case management and psychosocial rehabilitation. Peer support specialists specifically assigned to a high-functioning team can provide highly e□ective and billable services.

As discussed earlier, routine administrative or documentation tasks from the psychiatric provider and behavioral health counselors to other sta□ should permit more e□cient use of their time. This cost-o□set approach allows for a billable provider to become more e□cient with their time and increase care access.

There may also be incentives available for meeting quality metrics. These are common among health plans and public funders may be receptive to negotiation of quality payment arrangements at this transitional time. Metrics might include:

- Substance use disorder (SUD) screening approaches, including Screening, Brief Intervention and Referral to Treatment (SBIRT), the AUDIT-C plus 2 measure, etc.
- Collaboration and provider coordination.
- Medication education and medication adherence.
- Other screening, such as labs and physical health metrics. In Michigan, for instance, CBHC centers are incentivized (or penalized) on standard behavioral Healthcare E□ectiveness Data and Information Set (HEDIS) measures.
- Reductions in acute psychiatric admissions.
- Reductions in emergency department visits.

Finally, consideration of the financial cost of supporting team-based care should also include the potential financial losses incurred with sta□ turnover, particularly psychiatrists, who find managing complex cases in the absence of a team untenable. The overall cost of replacing a full-time psychiatrist, including lost productivity and recruiting costs, can be extremely high.

Medicare and Team-based Care Reimbursement

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule for chronic care management (CCM) services furnished to Medicare-insured persons with multiple chronic conditions (Department of Health and Human Services, 2019). At this time, a number of chronic care management current procedural terminology (CPT) codes (CPT 99490) and complex chronic care management codes (CPT 99487 and CPT 99489) are in use in primary care but are not available to mental health organizations to bill. These would be a productive means of supporting team-based care in the CBHC setting. The exclusion of mental health organizations from this billing stream appears to be a violation of the Mental Health Parity and Addiction Equity Act and should be approached as such by psychiatric advocacy groups.

After January 1, 2021 Medicare will allow billing outpatient clinic Evaluation and Management (E&M) codes (CPT 99201-99215) based on the total duration of time spent to the benefit of the patient or based or the complexity of medical decision making. Time spent to the benefit of the patient can include time consulting or coordinating with other members of the patient's team regarding that specific patient. This allows prescribing team members to bill at higher rates when aspects of team care require work without the patient present.

RECOMMENDATIONS

RECOMMENDATIONS FOR CBHCs AND ADVOCATES

We recommend implementing a team-based model of behavioral health care for people with SMI. It is expected to improve psychiatric and medical clinical outcomes, access issues, services provision experience for all members of the team, retention and financial sustainability in a value-based environment.

Implementation will require an investment in sta, time and workflow change. CBHC chief executive o cers and leaders must sponsor this e ort and communicate with sta in an intentional way to create engagement around change. Because it is a complex process, organizations should consider implementation in sequential steps: 1) team-based care, then 2) physical and behavioral health integration. Team-based care is essential for e ective and e cient integrated health and ideally is done before integration, but if that is not possible, as part of integration.

As is possible in local environments, strongly consider engagement and negotiation with payers around a CBHC's ability to meet payers' needs for overall improvements in quality and in cost management. At this time, payers are incentivized to consider such arrangements, even on a pilot basis.

In a financial environment moving toward value-based payment and away from a fee-for-service model, advocate for a payment model that will support team-based care by capturing improvements in overall medical spending is essential for the continued health of CBHCs and similar models. It is worth helping policymakers reframe their understanding of mental health outcomes that the more e cient approach to population care provided by this model could improve, including the often-invisible cost of chronic access problems to other providers and the person receiving services and their families.

THE NEED FOR FURTHER RESEARCH

While research in the business and primary care literature convey the e ectiveness and cost savings associated with team-based approaches, evaluation and implementation research in the mental health and addiction treatment and recovery space is needed. Given the broad adoption of integrated behavioral and physical health approaches to care which require team-based care provision, the health care field would benefit from a more comprehensive understanding of key elements of team-based services design and delivery.

CONCLUSIONS

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NAVIGATE: TREATMENT INTERVENTION FOR FIRST EPISODE PSYCHOSIS (RAISE TRIAL)

Navigate is based on a coordinated specialty care model – a form of high-functioning team-based-care where a team of providers, including a psychiatrist, a family clinician, an individual resiliency therapist and a supportive employment and education specialist work in close collaboration to provide optimal multimodal care to individuals early in the course of psychotic illnesses. This has resulted in improved outcomes. According to a review of outcomes of first-episode psychosis, "specialized interventions … are associated with higher person satisfaction with treatment and improved personal well-being, characterized by better sense of purpose, motivation, curiosity and emotional engagement. These improvements translated into better quality of life and greater involvement in school and work, with an overall reduced burden to the family," (Fusar-Poli, 2017).

COLLABORATIVE CARE MODEL

The collaborative care model uses a team to provide behavioral health services in the primary care setting. While the use of the collaborative care model has been robustly validated in the primary care setting, it does not have a clear evidence base in the community mental health and addiction recovery setting. However, it has been used explicitly as the organizing principle for very successful programs in that setting, most notably the Missouri Community Mental health and addiction recovery Center Health Home program, which showed impressive improvements in person health outcomes and overall cost reduction, tasks which have been di□cult to match in other programs of the kind (HealthNet, 2017).

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